HIP Skilled Nursing Facility Reimbursement Policy

10/12/2022

Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning

OMPP HIP Policy Change/Implications

Policy Change – Effective November 1, 2022

OMPP will direct MCEs to use an adjusted Medicare equivalent rate for the reimbursement of HIP members in nursing facilities.

Implications - MCEs

1. Duplicative pharmacy payments –

- Medicare Part A is an all-inclusive payment and includes payment for most pharmacy/lab/radiology services
- MCEs currently reimburse member nursing home stay pharmacy/lab/radiology services separately and mirror Medicaid FFS payment structure
- To mitigate OMPP will direct MCEs to develop a process to remove the 3X Non-Therapy Ancillary (NTA) Medicare variable per diem adjustment from the first three days of the member's stay – this will remove large upfront drug costs from the Medicare payment calculation

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OMPP HIP Policy Stakeholder Implications
1. MCEs that are paying 130% of Medicaid will need to implement adjusted Medicare based payments 2. MCEs that are paying Medicare rates will need to make adjustments to account for initial 3-day payment 3. MCEs will revise nursing facility provider contracts to pay all at adjusted Medicare based rate, as needed 4. SNFs will include Medicare code on all claims (HIPPS and PDPM) 5. OMPP will update the HIP reimbursement policy 6. OMPP will amend the 2022 HIP capitation rates

Managed Care Reimbursement for Nursing Facilities - Overview

Long-term care services are not included in the scope of benefits provided to members in the Healthy Indiana Plan (HIP), Hoosier Care Connect (HCC), or Hoosier Health Wise (HHW) managed care plans. However, managed care entities (MCEs) may provide coverage for skilled services in a nursing facility (NF) on a short-term basis if this setting is more cost-effective than other options and if the member can obtain the care and services needed.

Currently, the State of Indiana contracts with five (5) managed care entities to provide skilled services in nursing facilities across the state. Those managed care entities and the plans they support are as follows:

1. MDwise - HIP, HHW
2. CareSource - HIP, HHW
3. Managed Health Services (MHS) – HIP, HCC, HHW
4. Anthem - HIP, HCC, HHW
5. UnitedHealthcare - HCC

Managed Care Reimbursement for Nursing Facilities – Current Approaches

MCEs reimburse nursing facilities at 100% of the facility specific Medicaid rate for members covered under the Hoosier Healthwise (HHW) and Hoosier Care Connect (HCC) programs. reimburse at 100% of the Medicaid rate.

For Healthy Indiana Plan (HIP) MCEs reimburse nursing facilities at a member specific Medicare rate equivalent or at 130% of the facility specific Medicaid rate.

HIP Reimbursement Feedback Received from:

Nursing Facilities

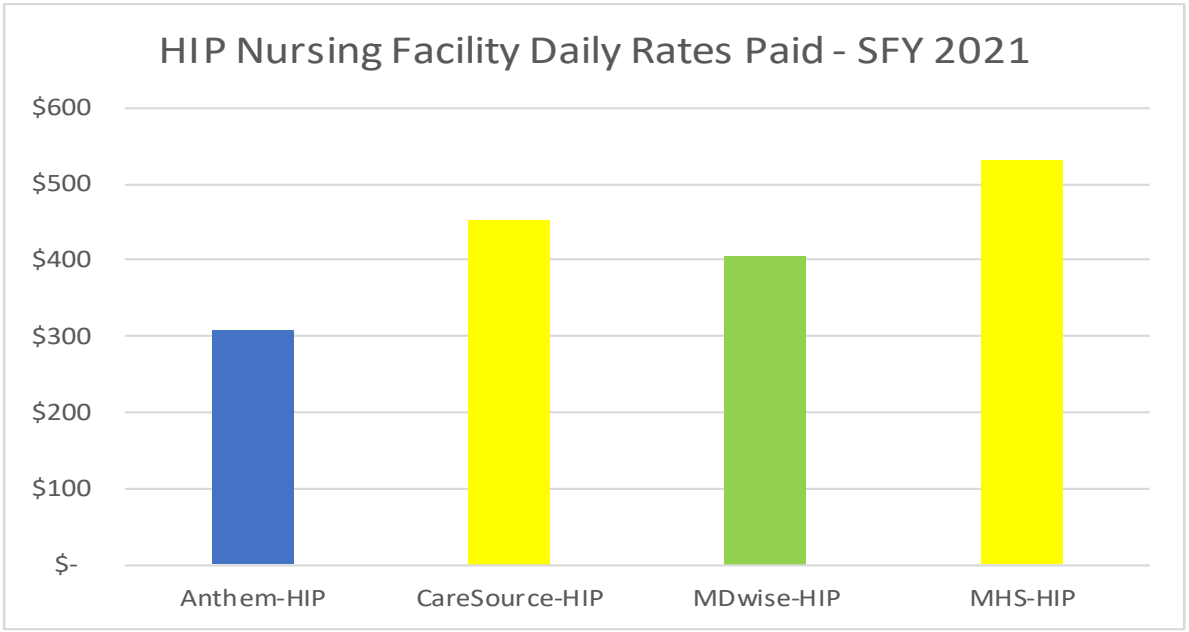
- Inconsistent MCE reimbursement
- Payments at 100% or 130% of Medicaid

Require retroactive adjustments

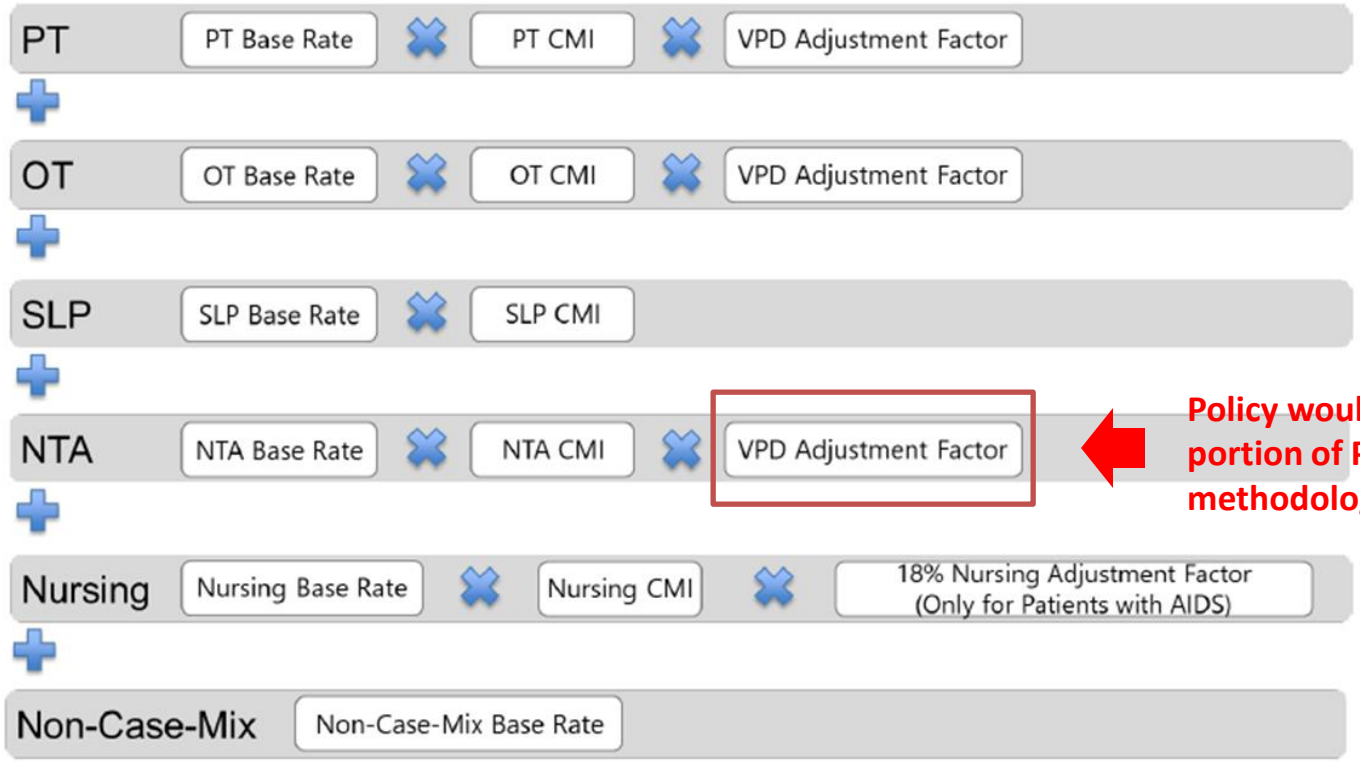
MCEs

- Lack of guidance for reimbursement for HIP members in NFs
- Access requested for Preadmission Screening and Resident Review (PASRR) and Level of care (LOC) data

Managed Care Nursing Facility Spend
Average HIP Daily Payments Vary by MCE



Patient Driven Payment Model (PDPM) Medicare Payment Methodology



Policy would alter this portion of PDPM payment methodology

Source: CMS Presentation, "Patient Driven Payment Model: Background & Finalized Changes to the Skilled Nursing Facility (SNF) Prospective Payment System (PPS)"

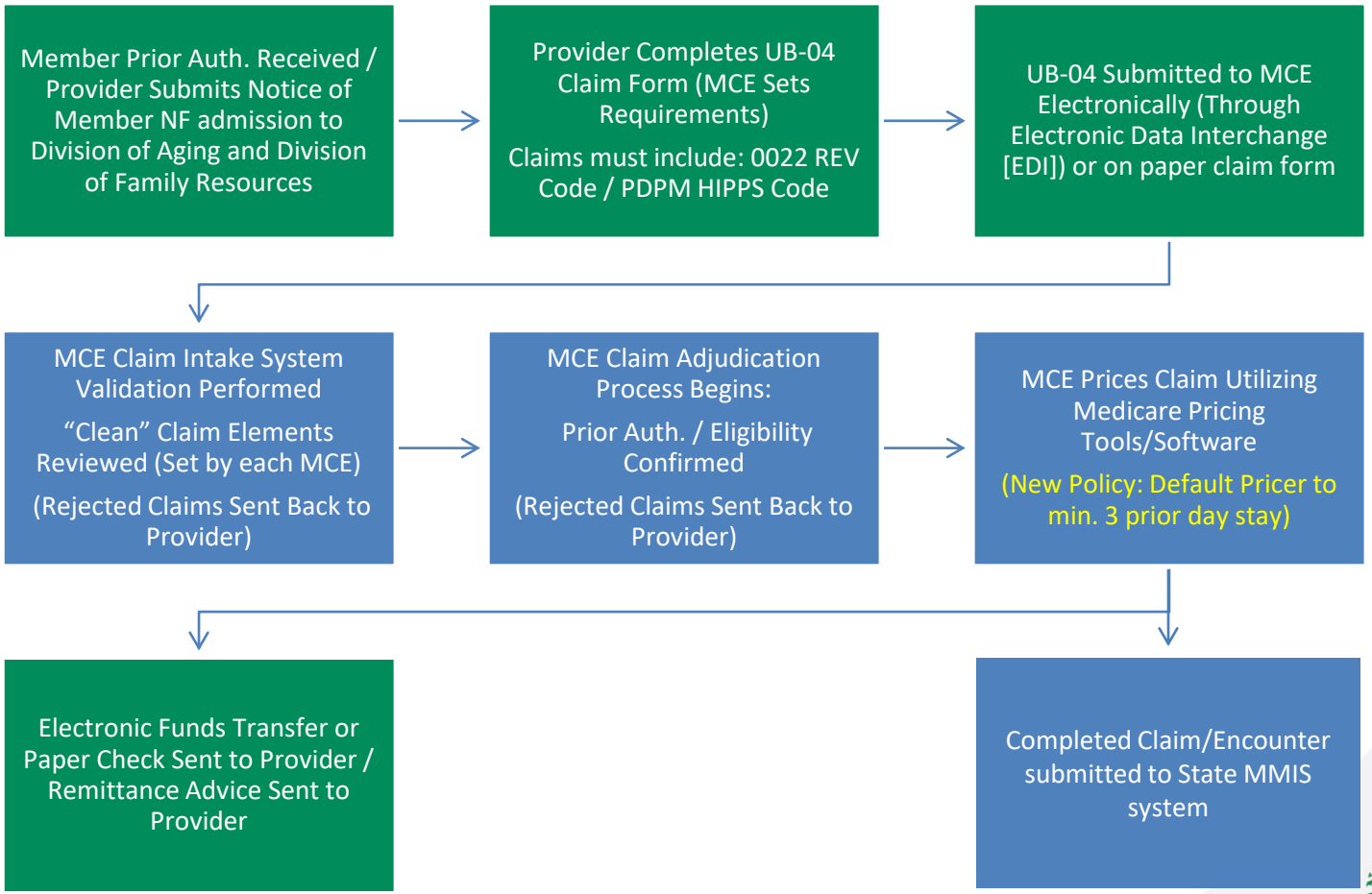
PDPM Variable Per Diem Schedule

Physical Therapy & Occupational Therapy Components			
Day in Stay	Adjustment Factor	Day in Stay	Adjustment Factor
1 - 20	1.00	**63 - 69**	0.86
21 - 27	0.98	**70 - 76**	0.84
28 - 34	0.96	**77 - 83**	0.82
35 - 41	0.94	**84 - 90**	0.80
42 - 48	0.92	**91 - 97**	0.78
49 - 55	0.90	**98 -100**	0.76
56 - 62	0.88		

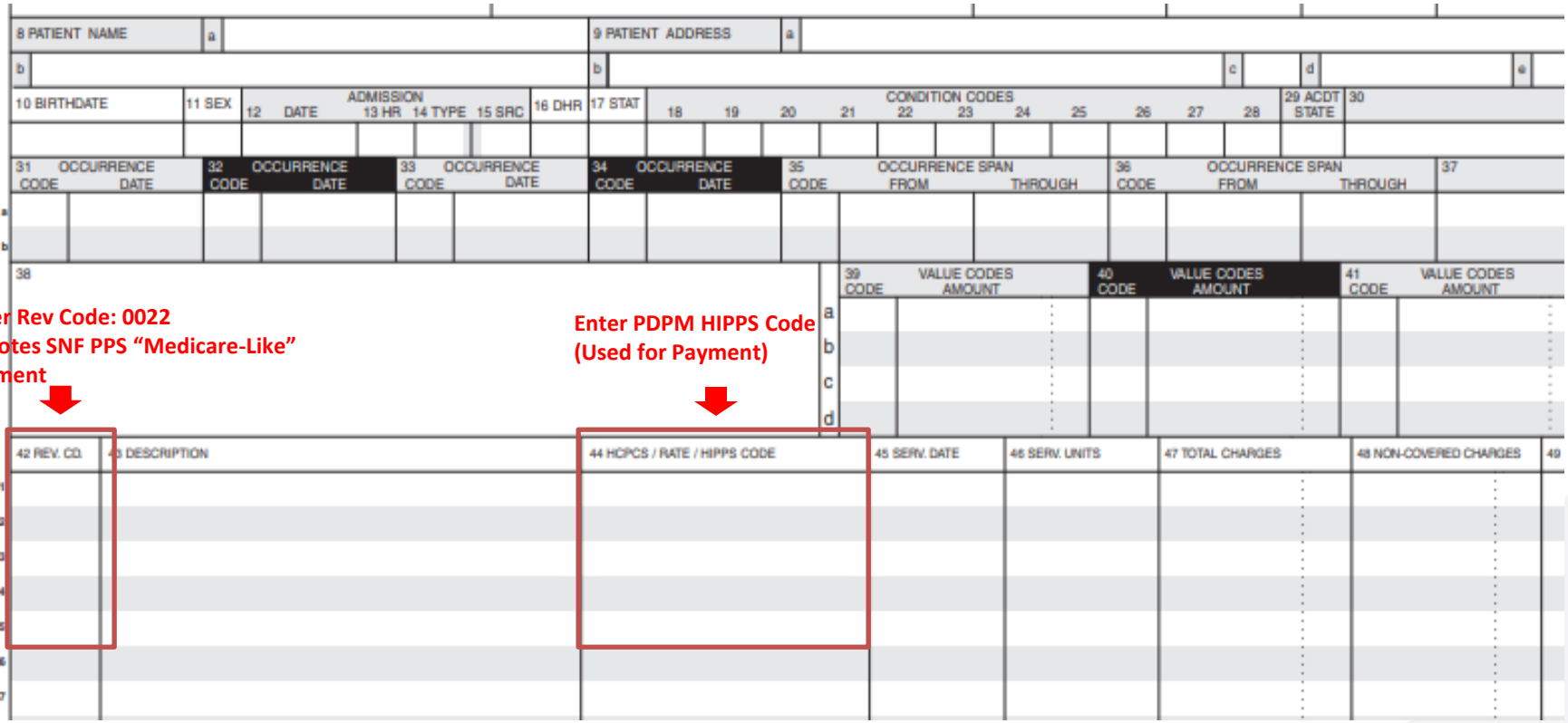
NTA Component	
Day in Stay	Adjustment Factor
1 - 3	3.00
4 - 100	1.00

- Policy will eliminate the 3X adjustment factor to the Non-Therapy Ancillary (NTA) component of PDPM
- The 3X multiplier was created mostly to account for the expected high initial pharmacy expense of SNF residents, which is reimbursed separately in the HIP program

HIP Claim Cycle



Provider UB-04 Claim Requirements

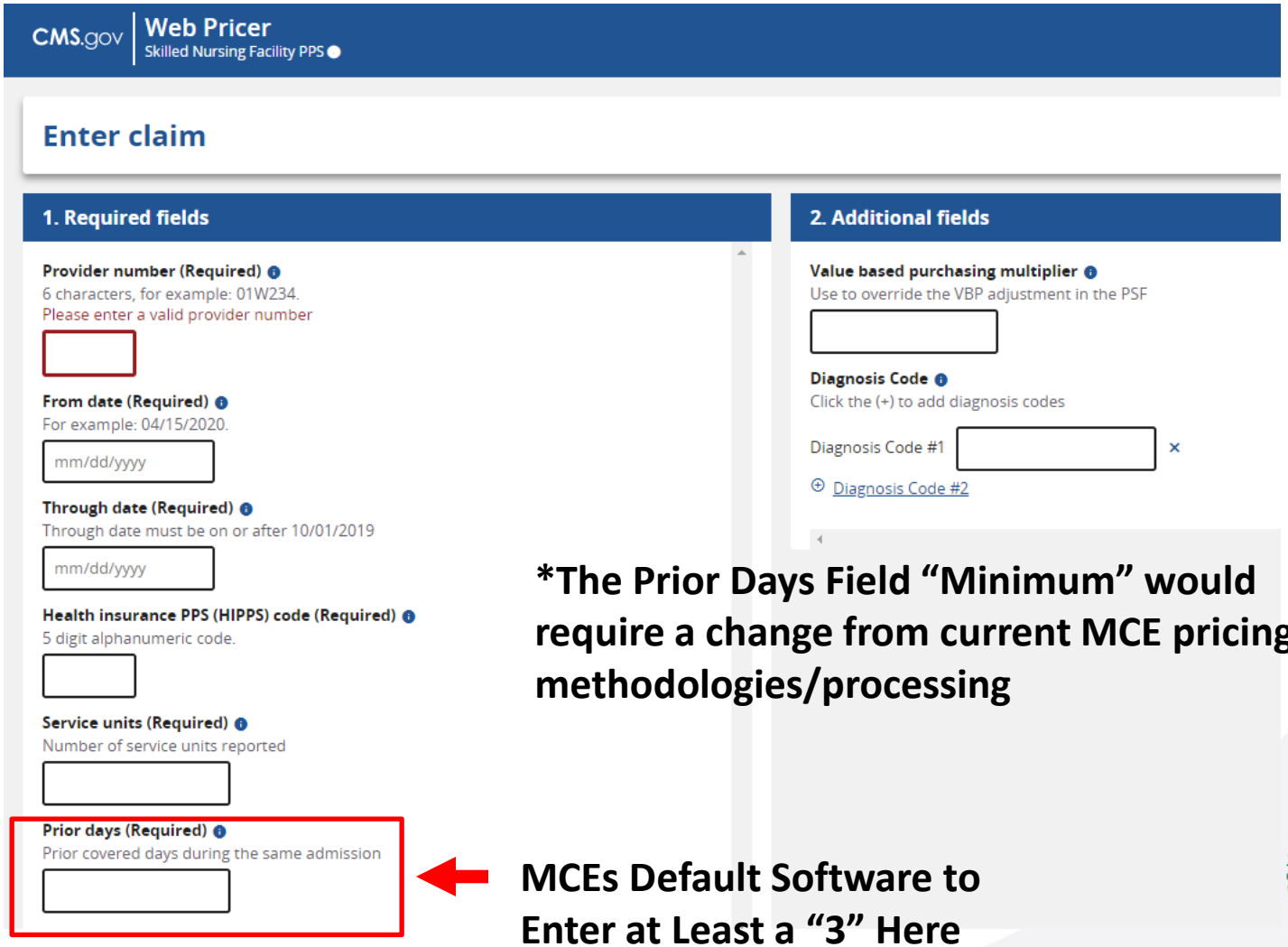


Enter Rev Code: 0022
Denotes SNF PPS "Medicare-Like" Payment

Enter PDPM HIPPS Code (Used for Payment)

- **For HIP "Medicare-Like" billing, providers currently complete the above elements today.**
- **It is not anticipated at this time that MCEs would require changes of billing practice from providers.**

MCE SNF Pricing Software



***The Prior Days Field "Minimum" would require a change from current MCE pricing methodologies/processing**

MCEs Default Software to Enter at Least a "3" Here

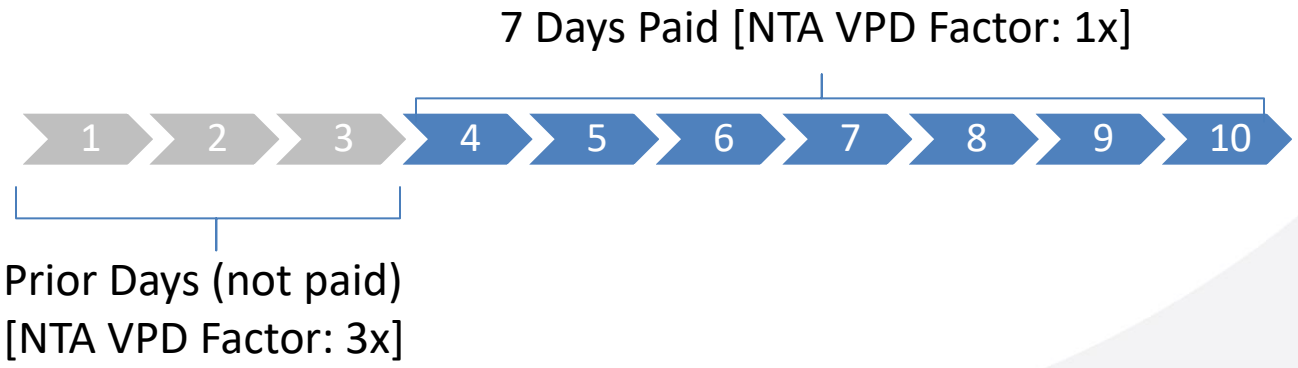
Example Payment Scenario

Provider

- **Provider bills for a 7-day prior authorized SNF stay. Provider will submit the UB-04 with rev code 0022 and the applicable PDPM HIPPS code to the MCE**

MCE

- **MCE verifies all claim elements present, member prior authorization, and member eligibility**
- **MCEs includes 3 prior days in the Medicare SNF pricer software for the claim span**
- **MCE pays 7 allowed days as if they were days 4 – 10 of the resident stay.**



OMPP HIP Policy Pros and Cons

Skilled Nursing Facilities

Pros	Cons
Will ensure consistency in MCE payment.	Reconciliation process may need to consider using the CMS Web-Pricer Tool.
Allows the high-cost drug carve out from the per diem.	
No changes when submitting claims on the UB-04.	
Monitor/ audit reimbursement methodology when there is consistency.	
Decrease in the need for claim disputes.	
Less provider abrasion.	

Pros/Cons
Medicare Equivalent vs. 130% of Medicaid Rate

Below are a list of PROS/CONS to implement a Policy for MCEs to pay a Medicare equivalent rate.

PROS

- Aligns with spirit of HIP regulations
- Consistency across all 4 MCEs
- Eliminates most retroactive processing needs (except facilities with no Medicare contract)
- All MCEs can support
- Request from nursing facility industry

CONS

- Increased program cost ($7M - $8M / year)
- MDwise - NF contract adjustments
- Adjustments needed due to pharmacy coverage issues
- Audit trail – PDPM validation

Pros/Cons
Medicare Equivalent vs. 130% of Medicaid Rate

MCEs

Pros	Cons
Decrease disputes.	Reconfiguration of claims payment to account for the 3 days prior.
Consistency in UB-04 submissions.	Configuration to adjusted Medicare pricing for those not already utilizing it.
Improved provider relations/ less provider abrasion.	
More equitable reimbursement.	
Implementation of HIP Rate Standardization go-live January 2024 so this change is only until that goes live.	

Medicare Rating Detail

Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) health insurers use to make payment determinations under several prospective payment systems. A standard patient assessment instrument is interpreted by case-mix grouping software algorithms, which assign the case mix group.

The Patient Driven Payment Model (PDPM) is a case-mix classification system for classifying skilled nursing facility (SNF) patients in a Medicare Part A covered stay into payment groups under the SNF Prospective Payment System.

The PDPM classification methodology utilizes a combination of six payment components to derive payment. Five of the components are case-mix adjusted to cover utilization of SNF resources that vary according to patient characteristics.

PDPM also includes a “Variable Per Diem (VPD) adjustment” that adjusts certain PDPM component per diem rates over the course of the stay.

Non-Therapy Ancillary (NTA) Component

The Patient Driven Payment Model (PDPM) resident classification system includes a Non-Therapy Ancillary (NTA) component in the Medicare Part A reimbursement rate. The NTA component includes payment for pharmacy, laboratory, radiology, IV therapy and supplies, and respiratory/inhalation therapy services. Currently, Managed Care Entities (MCEs) are required to pay for the medical and routine pharmacy needs of a managed care plan member residing in a nursing facility through the Medicaid pharmacy benefit (effective as of 1/1/2022). This aligns payment benefits with the Medicaid fee-for-service program.

With the NTA component already including payment for many of the MCE members pharmacy needs, there is a need to address the potential for duplicate reimbursement for member pharmacy services. The NTA component features a 3X multiplier on the NTA component rate for the first three days of a Medicare nursing facility stay. This 3X multiplier is to account for the high upfront costs of a member entering a nursing home, which is predominantly driven by pharmacy needs.

To mitigate the impact of any duplicative reimbursement by following a Medicare like payment methodology, OMPP is requiring that MCE Medicare pricing/payment tools have a minimum 3 day prior stay noted in the appropriate fields, which in turn will eliminate the 3X NTA multiplier from being paid on the claim.

Questions?

2022 IHCP Works Post-Seminar Survey

Please scan the QR code or click the link below.

https://infssa.az1.qualtrics.com/jfe/form/SV_0xirs6kAcftal4W